U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 19 December 2006

In the Matter of:
D.L. S.

Case No. 2006-BLA-05308

Claimant
v.

WESTMORELAND COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:[1]
Joseph Wolfe, Esquire
For the Claimant
Douglas Smoot, Esquire, Jackson & Kelly
For the Employer

BEFORE: DANIEL F. SOLOMON
Administrative Law Judge

DECISION AND ORDER

Award of Benefits

This proceeding arises from a request for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* The Claimant filed three applications for federal black lung benefits. Claimant's first claim for benefits was withdrawn. His second application for benefits was filed on October 28, 2002. DX 1, p.277. The claim was denied by the Director, Office of Workers' Compensation Programs on September 30, 2003. DX 1, p. 7. The Claimant filed this claim December 22, 2004. Director's exhibit, "DX" 2. After the Claimant was awarded interim benefits, the Employer requested a hearing on December 29, 2005. DX 35.

Claimant was last employed in coal mine work in the state of Virginia, the law of the United States Court of Appeals for the Fourth Circuit controls. See ***Shupe v. Director,***

1 The Director, Office of Workers' Compensation Programs, was not present nor represented by counsel at the hearing.

OWCP, 12 BLR 1-200, 1-202 (1989)(en banc). Since Claimant filed this application for benefits after January 1, 1982, Part 718 applies.

At hearing June 27, 2006, 38 Director's exhibits were entered into evidence as DX 1-DX 38 for identification, Transcript, "TR" at 5. Three Claimant's exhibits, "CX" 1-CX 3, TR 9, and eleven Employer's exhibits, EX 1-7 and EX 9- 12, TR 9, 13, were also admitted for identification.[2] The record remained open for briefs. Both Claimant and the employer filed briefs.

STIPULATIONS

The parties agreed to the following:

1. The timeliness of the claim is no longer being contested. TR 5.

Timeliness is a jurisdictional matter that can not be waived. 30 U.S.C. § 932(f), provides that "[a]ny claim for benefits by a miner under this section shall be filed within three years after whichever of the following occurs later": (1) a medical determination of total disability due to pneumoconiosis; or (2) March 1, 1978. The Secretary of Labor's implementing regulations at 20 C.F.R. § 725.308 sets forth in part, as follows:

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

I have reviewed all of the evidence in the record and no evidence exists to rebut the presumption.

2. The Claimant had 24 years of coal mine employment. TR 6.
3. The Claimant was a miner, and he worked after December 31, 1969. TR 6.
4. Westmoreland Coal Company is the responsible operator. TR 6.
5. The Claimant has two dependents. TR 6.
6. The Claimant has a total disability from a respiratory impairment. TR 14.

After a review of the entire record, I accept the stipulations.

ISSUES

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under the Part 718 standards. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment ("CME"), (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. *See* 20 C.F.R. §§ 718.201-718.204. The following will be addressed:

2 Note that proposed EX 8 and EX 4 were withdrawn. TR 11, TR 19. Actually, EX 9,EX 10, EX 11 and EX 12 also exceed the evidentiary limitations. TR 21. However all are made part of the record for identification purposes.

1. Whether the miner suffers from pneumoconiois.
2. If so, whether the miner's pneumoconiosis arose out of coal mine employment.
3. If so, whether the miner's disability is due to pneumoconiosis.

BURDEN OF PROOF

"Burden of proof," as used in this setting and under the Administrative Procedure Act[3] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[4] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [***Ondecko***], 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[5]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

Testimony

The Claimant did not testify.

Record Evidence

On his application for benefits, Claimant stated that he had worked in the coal mines for 24.5 years ending in July 1995. DX 3. The Claimant indicated that his jobs include general laborer, high wall drill operator, general roof drill operator and utility worker from April 1971 through August 1995. DX 4. The Description of Coal Mine Work and Other Employment form indicates that the miner's last job required him to build brattices requiring frequent heavy lifting and carrying. DX 5.

---

[3] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[4] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [***Sainz***], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[5] Also known as the risk of nonpersuasion, *see* 9 J. Wigmore, **Evidence** § 2486 (J. Chadbourn rev. 1981).

MEDICAL EVIDENCE

Chest x-ray evidence

Exhibit No.	Physician	B-Reader (B)/ Board Cert. (BCR)	Date of X-ray study	Date of Reading	Film Quality	Reading
DX 14	Rasmussen	B	3/15/05	3/16/05	1	1,1[6]
EX 2	Wiot	B/BCR	"	12/07/05	2	Negative
EX 1	Castle	B	7/20/05	8/01/05	1	Negative
CX 2	Deponte	B/BCR	"	5/30/06	1	2,2
EX 3	Hippensteel	B	11/16/05	11/16/05	1	Negative
CX 3	Deponte	B/BCR	"	6/7/06	1	2,2
CX 1	Rasmussen	B	12/20/05	12/21/05	1	1,1
EX 2	Wiot	B/BCR	"	4/13/06	1	Negative

Pulmonary function studies

Exhibit No.	Physician	Date of study	Tracings present?	Flow-volume loop?	Broncho-dilator?	FEV1	FVC/ MVV	Coop. and Comp. Noted?
DX 14	Rasmussen	3/15/05	Yes	No	Yes	1.67 1.77	4.24 4.44	Yes7
EX 1	Castle	7/20/05	Yes	Yes	Yes	1.48	3.26/54	No
EX 3	Hippensteel	11/16/05	Yes	Yes	Yes	1.30 1.44	3.05/42 3.33	No
CX 1	Rasmussen	12/20/05				1.69 1.79	3.92 3.94	

Blood gas studies

Exhibit No.	Physician	Date of Study	Altitude	Resting (R) Exercise (E)	PCO2	PO2	Comments
DX 14	Rasmussen	3/15/05		R E	38 42	70 65	
EX 1	Castle	7/20/05		R	38.3	69.3	

[6] This x-ray was also read by Dr. Peter Barrett, M.D., also B/BCR who read it for quality purposes only. DX 14.

[7] Dr. Renn reviewed this test for validity, and determined that the values were valid. DX 27.

EX 3	Hippensteel	11/16/05		R	39.1	70.7	
CX 1	Rasmussen	12/20/05	0-2999	R	41.0	69.0	

Medical reports

Dr. Donald Rasmussen

Dr. Rasmussen performed the Department of Labor examination on March 15, 2005. The Claimant was 56 years of age. He reported that he had smoked since 1969. He worked in the mining industry from 1972 until 1995 for total of 23 years performing considerable heavy manual labor. The chest film indicated pneumoconiosis category 1/1 s/s throughout all lung zones as well as bilateral apical nodules. Pulmonary function studies revealed severe, slightly reversible obstructive ventilatory impairment. The diffusing capacity was moderately reduced. There was minimal resting hypoxia. He was mildly hypoxic during exercise testing. Overall, the studies indicated marked loss of lung function due to severe obstructive impairment. Dr. Rasmussen determined that the Claimant did not retain the pulmonary capacity to perform his last regular coal mine job. Dr. Rasmussen determined that the impairment was caused by a combination of smoking and coal mine dust exposure which are not distinguishable through radiographic or physiologic means. DX 14.

A second examination was performed by Dr. Rasmussen on December 20, 2005. The chest x~ray showed the presence of pneumoconiosis category 1/1 s/s throughout all lung zones. Pulmonary function studies revealed a severe, irreversible obstructive ventilatory impairment with a moderately reduced diffusing capacity. There was minimal resting hypoxia. Overall, the studies indicated the presence of marked loss of resting lung function as reflected by the pulmonary function studies sufficient to cause disability. Dr. Rasmussen determined that the condition was caused by a combination of smoking and coal mine dust exposure given that the effects of each cannot be distinguished by physical, physiologic or radiographic means. Again, Dr. Rasmussen determined that total disability came from a combination of smoking and coal mine dust exposure. CX 1.

Dr. James R. Castle, M.D.

Dr. Castle, board certified in internal and respiratory medicine, examined the Claimant on July 20, 2005. An x-ray was read as negative. Dr. Castle found the Claimant has total disability from tobacco smoked-induced bullous emphsyema with a significant asthmatic component. EX 6 at 18. He noted that the Claimant worked in or around the underground mining industry for a sufficient enough time to have developed coalworkers' pneumoconiosis if he were a susceptible host. He last worked in 1995 and left the industry because the mine shut down. The last 18 or 20 years he was a roof bolting machine operator.

Dr. Castle noted that another risk factor for the development of pulmonary disease is that of tobacco abuse. He attributed at least a 30 pack-year smoking history to Claimant. "This is a sufficient enough exposure to have caused him to develop chronic obstructive pulmonary disease, i.e. chronic bronchitis/emphysema and/or lung cancer and/or atherosclerotic cardiovascular disease if he were a susceptible host. This was further substantiated by an elevated carboxyhemoglobin level both at the time of my evaluation and at the time of Dr. Rasmussen's evaluation."

Dr. Castle also noted that another risk factor for the development of pulmonary symptoms is cardiac disease. A history of having an irregular cardiac rhythm and an abnormal electrocardiogram consistent with coronary artery disease is reported.

Another noted risk factor for the development of pulmonary disease is bronchial asthma. Intermittent episodes of wheezing that seem to be made worse by being around hair sprays, perfumes and so forth was reported. Dr. Castle also noted a "very" marked degree of reversibility in his airway obstruction. "It is likely that he has a significant asthmatic component to his airway obstruction….At no time did he demonstrate any consistent physical findings indicating the presence of an interstitial pulmonary process. He did not have a consistent finding of rates, crackles, or crepitations."

Dr. Castle rendered an opinion that Claimant did not have radiographic evidence of coalworkers' pneumoconiosis. He did have evidence of bullous emphysema. "While Dr. Rasmussen felt that the x-ray was positive, he described the presence of linear, irregular type opacities classified as s. These findings are not typical of coalworkers' pneumoconiosis. They are frequently seen in individuals who are heavy tobacco users. It remains my opinion with a reasonable degree of medical certainty that he does not have radiographic evidence of coalworkers' pneumoconiosis." EX 1. This is reiterated in a deposition. EX 6.

Dr. Kirk Hippensteel

Dr. Hippensteel, board certified in internal and respiratory medicine and a B reader, examined the Claimant on November 16, 2005. An x-ray was read as negative. According to Dr. Hippensteel, the examination revealed bullous emphysema and some compression of lung markings in lung bases referable to bullae in upper lobes. He also has variable air flow obstruction with significant reversibility at times, which is not typical for coal mine dust-induced lung disease, which causes a fixed impairment. EX 3. In his deposition, Dr. Hippensteel testified that the testing he performed shows that the Claimant is disabled from a respiratory impairment. EX 7 at 23-24. In his report, it was his opinion with a reasonable degree of medical certainty that [Claimant] does have a disabling respiratory process. it is my opinion that this disabling respiratory process is due to tobacco smoke induced airway obstruction with a significant asthmatic component, it is my opinion he is not permanently and totally disabled as a result of a coal mine dust induced lung disease or coalworkers' pneumoconiosis. it is my opinion that he may be permanently and totally disabled as result of cardiac disease. This is a disease of the general public at large and is unrelated to coal mine dust exposure and coalworkers' pneumoconiosis.

In his report, Dr. Hippensteel noted that he disagreed with Dr. Rasmussen that his radiographic findings are suggestive of pneumoconiosis. "It is also known that bullous disease is a congenital problem and is not associated with simple pneumoconiosis from coal mine dust. It can be associated with some diffusion impairment, as has been noted in this case. The findings on my examination and that of Dr. Castle are not altered significantly by the findings on Dr. Rasmussen's examinations in this case, and show with a reasonable degree of medical certainty that this man has disease related to his continued cigarette smoking and bullous emphysema rather than coal workers' pneumoconiosis, as claimed by Dr. Rasmussen. Dr. Rasmussen's claim that there are no differentiating factors that make it possible to separate a diagnosis of coal workers' pneumoconiosis from disease caused by cigarette smoking or other problems makes me give little weight to his conclusions, since he claims that diagnoses have no differentiating characteristics that make it possible to distinguish one lung disease from another. The articles he

cites do not prove his point. There are differentiating findings in specific individuals making it possible to delineate cause of disease with a reasonable degree of medical certainty as has been done by Dr. Castle and myself in this case. Dr. Rasmussen's inability or unwillingness to differentiate findings in order to make a proper diagnosis shows the limits of Dr. Rasmussen's expertise, and is the reason why the weight of his conclusions in this case are diminished." EX 3.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Total Disability

To receive black lung disability benefits under the Act, a claimant must establish total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

The record does not contain any evidence that Claimant has complicated pneumoconiosis and there is no evidence of cor pulmonale with right sided congestive heart failure. As a result, the Claimant must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

I accept that the preponderance of the evidence establishes that all of the medical opinions accept total disability. DX 14, CX 1, EX 1, EX 3, EX 6, EX 7.

Both of the Employer's expert witnesses, however attribute the totally disabling respiratory impairment to smoking cigarettes. EX 1, EX 3, EX 6, EX 7.

Therefore, I find that the Claimant has established that he is totally disabled from a respiratory impairment.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or clinical, pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) *Legal Pneumoconiosis.* "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

The presence of pneumoconiosis is based on weighing all types of evidence under 20 C.F.R. § 718.202 together. ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 (4th Cir. 2000).

A review of all of the evidence shows that there are four positive interpretations and four negative interpretations. I am not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co***., 14 B.L.R. 1-70 (1990), although it is within my discretion to do so, ***Edmiston v. F & R Coal Co***., 14 B.L.R. 1-65 (1990).

I am also to consider the respective qualifications of the experts. Dr. Deponte and Dr. Wiot are both board certified B reader radiologists. Drs. Castle, Hippensteel, and Rasmussen are all B readers.[8]

"[W]here two or more X-ray reports are in conflict…consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." 718.202(a)(1). I am "not required to defer to…radiological experience or…status as a professor of radiology." ***Dempsey v. Sewell Coal Co***., 23 BLR 1-47 (2004).

I note that of the readers of record, Dr. Wiot is the best qualified.

Claimant has not established pneumoconiosis by the provisions of subsection 718.202(a)(2) since no biopsy evidence has been submitted into evidence.

20 C.F.R. § 718.202(a)(4) sets forth:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in Section 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

The Claimant relies on the opinions of Drs. Rasmussen. TR 54. The Employer relies on the opinions of Drs. Castle and Hippensteel. All find that the Claimant is totally disabled from a respiratory impairment.

Rationale

If I rely solely on "numerosity" on face of the readings, the Claimant has not shown that a preponderance of the readings of x-rays in the current record is positive, and at best is in equipoise. If I rely on physician qualifications, I will accept that Dr. Wiot is the best qualified x-ray reader in this record. Not only is he dually qualified, he is generally acknowledged as such. I reject the allegation that Dr. Wiot is "notorious for never offering a positive reading in black lung cases", as there have been cases to numerous to mention where that has not been the case. Moreover, if the Claimant seeks to impeach Dr. Wiot's credibility, allegations of party

[8] Although the Claimant inaccurately attributed status of board certified radiologist to Dr. Rasmussen in the Evidence Summary Form submitted to me.

affiliation, standing alone, do not establish improper bias. ***Brown v. Director, OWCP***, 7 B.L.R. 1-730 (1985).

However, I will discuss further analysis under ***Island Creek Coal Co. v. Compton,*** *supra,* to weigh the evidence. As set forth above, the Claimant bears the burden of proof. A 'reasoned' opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19 (1987). Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder-of-fact to decide. ***Clark v. Karst-Robbins Coal Co***., 12 B.L.R. 1-149 (1989)(en banc).

Claimant asserts that the record is very clear and unequivocal with respect to the identity of claimant's respiratory condition. Dr. Rasmussen specifically stated that the combined impact of coal mine dust exposure and smoking caused the miner's impairment. However, if I find the x-ray evidence is not persuasive, the Claimant must explain why legal pneumoconiosis exists.

The Claimant argues that there is an issue regarding "reversibility" and that employer's experts factually misinterpreted the data and rendered opinions that are hostile to the act. See Brief. I note the argument. As reversibility is often used as a measure whether total disability stems from pneumoconiosis or was produced by another source, it may be a factor.

Both Drs. Castle and Hippensteel emphasize findings of reversibility in the spiromentry. For example, Dr. Hippensteel explained that the Claimant has variable air flow obstruction with significant reversibility at times, which he explained is inconsistent with a coal mine dust induced lung disease. EX 3; EX 7 at 17-18. Dr. Castle made a similar finding. EX 6 at 15. In his deposition, Dr. Hippensteel was asked whether reversibility is present in people who have lung impairment due to pneumoconiosis.

> A No, it is expected that it causes a fixed and irreversible impairment, unless we're talking about industrial bronchitis, which I think is not an issue in this case, since this man had long ago left work in the mines and industrial bronchitis should subside within a period of several months after leaving work, so I think that it was not an issue in this case and therefore could not be expected that it would have been associated with reversibility as a diagnosis in this case.

EX 7 at 18.

First, Claimant alleges that both Drs. Castle and Hippensteel erred in the finding relating to reversibility:

> [B] oth Dr. Castle and Dr. Hippensteel indicated that the reversibility that appeared on their pulmonary function testing suggested that the impairment was not caused by coal dust exposure. Review of the remaining pulmonary function studies of record does not indicate the presence of significant reversibility in this case. The studies offered by Dr. Castle and Dr. Hippensteel are significantly out of line with the remaining evidence of record on this issue. Specifically, the before bronchodilator studies for Dr. Rasmussen's March 15, 2005 study and for the December 20, 2005 study resulted in values equal to or greater than 3.92 and showed no significant reversibility after the administration of bronchodilators. (DX-14, CX-l). The before bronchodilator studies performed by Dr. Castle and Dr. Hippensteel resulted in values equal to or greater than 3.26. This is a significant decrease during the year of 2005 considering that Dr. Rasmussen's studies were performed before and after those performed by the employer.

See Brief.

A review of the record shows that Claimant is factually correct. Moreover, even Dr. Castle admitted that there is a non-reversible portion of the impairment that is also disabling. EX 6 at 21-22.

Second, Claimant alleges:

> Dr. Castle's post bronchodilator study resulted in values that are essentially the same as the pre and post studies offered by Dr. Rasmussen. If we accept the fact so often proffered by the employer's physicians that the machines used for these studies can only be used to accurately determine the most that an individual can exhale under the given conditions, it is quite obvious that the same machines are not as accurate at measuring breathing capacity when inadequate effort or understanding is achieved by the individual being measured. It goes to reason that the only way to establish reversibility in a case like this one is to obtain a pre study that is lower that the individual's normally established maximum. Dr. Hippensteel and Dr. Castle managed to obtain such values on their pre studies. The results of their pre studies are significantly lower than the pre studies obtained by Dr. Rasmussen early in 2005 and late in 2005. This certainly can make it appear that [Claimant] suffers from a variable obstructive impairment when, in fact, no variability exists. The values obtained by Dr. Hippensteel and Dr. Castle on the pre studies are not credible in this case and should be totally disregarded as well as all of the conclusions they reached as a result of those values.

See Brief.

In his deposition, Dr. Hippensteel was asked regarding his reading of the x-ray he had taken. EX 7 at 29-34. On direct examination, he testified that pneumoconiosis was negative with a classification of 0/0, with increased basilar markings bilaterally that were irregular in character and not suggestive of coal workers' pneumoconiosis. Id. 14. He later testified that pneumoconiosis findings were rounded and not irregular. On cross examination, he admitted that irregular opacities are consistent with a type of pneumoconiosis. Id at 31, lines 9-11. He also admitted that the form used asks the reader to mark any opacities that are compatible with a form of pneumoconiosis. Id. at line 19. When asked again, he vacillated, and recanted this testimony. Id 34 at lines 9-10.

Dr. Castle was not cross examined regarding his x-ray reading. EX 6. He thought the chest x-ray did not show any abnormalities consistent with pneumoconiosis.

> He did have evidence of severe bullous emphysema, particularly in the upper lung zones, which causes crowding in the lower zone structures, and that indicated that there was some increased marking there….He also had fairly marked displacement of the right minor fissure due to the bullae that was present.
>
> Q. Were these linear markings in the bases of his lungs?
>
> A. They were.

EX 6 at 13.

Dr. Castle admitted that bullous emphysema has a "Swiss cheese" effect, as there are empty air spaces or holes made in the lung and that that both smoking and coal dust can damage the lungs simultaneously. Id. at 23. However, he maintains that it did not in this case. Id.

I note that during the time he was examined by Dr. Hippensteel no symptoms were noted but that during the time he was examined by Dr. Castle, wheezing was produced, but Dr. Castle emphasized that there was not a "consistent" finding of rales, crackles or crepitations. I note that despite this, Dr. Castle determined that the Claimant is totally disabled from a respiratory standpoint.

In reviewing the Radiographic Interpretation Form used by all readers in this case, I note that the form states, "abnormalities consistent with pneumoconiosis".

Based on an evaluation of all the evidence, I find that the Claimant has established pneumoconiosis based on x-ray. I find that Dr. Hippensteel admitted through close cross examination in testimony that his findings were compatible to and consistent with pneumoconiosis, although he did not mark the form accordingly. I accept that he testified that pneumoconiosis can manifest itself in both rounded and irregular shaped opacities, and that the form requires him to set forth any opacity that is compatible with pneumoconiosis, and that he failed to do so. Therefore, I give his reading reduced effect.

Dr. Wiot was not deposed. In reading Dr. Wiot's evaluations, although he found no evidence of coal worker's pnemnoconiosis, he noted prominent bullous changes in both upper lung fields with compression of normal vascular markings in both bases, and an area of disc atelectasis or linear scarring at the right base. Although I find that he is the best qualified reader, given that the testimony of Dr. Hippensteel regarding whether compatible or comparable or consistent markings must be identified as pneumoconiosis, I find that there is some question whether his findings are consistent with or compatible with pneumoconiosis, and therefore give his opinion less weight.

I do not strike or discount all of Dr. Hippensteel's testimony, but I find that Dr. Hippensteel's testimony shows that he is reluctant to find legal pneumoconiosis even if he is not "hostile to the act" and attribute little weight to his opinions as to diagnosis. Dr. Hippensteel rejects the concept that there is an assumption of progressivity that underlies much of the Black Lung statutory regime. His logic in reliance on "reversibility" as a test for pneumoconiosis is premised on a false assumption about the nature of pneumoconiosis. [9] Dr. Hippensteel rejects post coal mine employment symptoms of chronic obstructive pulmonary disease as a matter of course, contrary to the assumption. Pneumoconiosis is both progressive and latent.10 ***Eastern Associated Coal Corp. v. Director, OWCP***, 220 F.3d 250, 255 (4th Cir. 2000); ***Lane Hollow Coal Co. v. Lockhart***, 137 F.3d 799, 803 (4th Cir. 1998) (''pneumoconiosis is progressive and irreversible''); ***Adkins v. Director, OWCP***, 958 F.2d 49, 51 (4th Cir. 1992) (''pneumoconiosis is a progressive disease''); ***Greer v. Director, OWCP***, 940 F.2d 88, 90 (4th Cir. 1991)

---

[9] To physicians, "pneumoconiosis" is a single disease, arising in whole from a specific cause (dust exposure), and producing a characteristic form of pulmonary damage. Id. To the law, "pneumoconiosis" is an array of diseases or effects, arising in whole or in part from dust exposure, and the form of pulmonary damage is irrelevant, so long as some impairment arises from it. ***Compton v. Beth Energy Mines, Inc***., 1998-B.L.A.-14 (1998) (citing ***Roberts v. West Virginia C.W.P. Fund***, 20 B.L.R. 2-69 (4th Cir. 1996). To Dr. Hippensteel, re: pneumoconiosis "… it is expected that it causes a fixed and irreversible impairment, unless we're talking about industrial bronchitis, which I think is not an issue in this case, since this man had long ago left work in the mines and industrial bronchitis should subside within a period of several months after leaving work, so I think that it was not an issue in this case and therefore could not be expected that it would have been associated with reversibility as a diagnosis in this case." EX 7 at 18. Underline added. Despite what Dr. Hippensteel asserts, in several unreported cases, ALJs have been sustained in finding that industrial bronchitis is pneumoconiosis. Boggs v. Director, 867 F.2d 611 (Table) (6th Cir., 1989); Industrial bronchitis was CWP. ***Florence Mining Co. v. Director, OWCP***, 188 Fed.Appx. 105 (3rd. Cir.,2006); ***Sea ""B"" Mining Co***. v. Dunford, 188 Fed.Appx. 191, (4th Cir., 2006); ***Cyprus Cumberland Resources v. Director***, 170 Fed.Appx. 787 (3rd. Cir., 2006); ***Dante Coal Co. v. Director***, 164 Fed.Appx. 338 (4th Cir., 2006). There is an unpublished case wherein a Circuit court that affirmed the opposite. ***Pittsburg & Midway Coal Minin Co. v. Sanchez,*** 18 Fed.Appx. 722 (10th Cir., 2001).

[10] In fact, if I follow his logic, if "industrial bronchitis" were not in this case, reversibility would not be an issue. Actually, there is no diagnosis of "industrial bronchitis".

(pneumoconiosis is ‘‘a slowly progressing condition’’). I attribute little weight to Dr. Hippensteel’s reading.

I give greater weight to the readings by Dr. Deponte. She is dually qualified. I give less weight to the reading of Dr. Castle, who is not dually qualified. I give significant weight to Dr. Rasmussen’s readings, as they are consistent with Dr. Deponte’s reading. Given my findings, the preponderance of the credited x-rays outweighs those that are negative. And I give more weight to Dr. Deponte’s opinion due to her dual certification as a board certified B reader radiologist.

Therefore, I find that the Claimant has established clinical pneumoconiosis. 20 CFR §718.202(a)(1).

Alternatively, I also find that the Claimant has provided a “reasoned” opinion that establishes legal pneumoconiosis. "Legal pneumonoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment, and includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. 718.201(a)(2). Dr. Rasmussen specifically stated that the combined impact of coal mine dust exposure and smoking caused the miner’s impairment. He examined the Claimant on two occasions. I find that his examinations and the results are more reliable than those done by Drs. Castle and Hippensteel as they did not perform exercise testing. He incorporated certain learned journal articles to substantiate his position.

I discount Dr. Hippensteel’s position on this issue. I find that his reliance on reversibility is misplaced. There is a factual discrepancy regarding the extent of reversibility in Dr. Rasmussen’s first exam and even in Dr. Hippensteel’s exam. I note that Dr. Rasmussen’s second examination does not find reversibility. Dr. Castle admitted that there is a non-reversible portion of the impairment that is also disabling. EX 6 at 21-22. This fact, standing alone impeaches Dr. Hippensteel’s rationale.

I also find, as noted above, Dr. Hippensteel has an extreme reluctance to find legal pneumoconiosis. It is more rational that there is aggravation by and to the lungs by multiple sources, including 24 years of coal mine employment. There is an assumption that pneumoconiosis is latent and progressive, but Dr. Hippensteel admittedly did not consider latency. EX 7, at 18.

Even Dr. Castle admitted that smoking and coal dust can damage the lungs simultaneously. Even if the bullous emphysema were congenital, the record also shows a diagnosis of asthma, and I find that it is rational that the emphysema can be aggravated by coal dust, and that Dr. Castle’s logic forecloses contribution by coal dust. Asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. ***Robinson v. Director, OWCP***, 3 B.L.R. 1-798.7 (1981); ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1983). In ***Hughes v. Clinchfield Coal Co.***, 21 B.L.R. 1-134, 1-139 (1999), the Board held that chronic bronchitis and emphysema fall within the definition of pneumoconiosis if they are related to the claimant's coal mine employment.

Claimant argues that Dr. Castle and Dr. Hippensteel failed to state how partial reversibility, if present at all, can preclude the Claimant from suffering from damage to his lungs caused by coal mine dust exposure. Claimant maintains that it is not logical to conclude that a miner cannot suffer from the effects of coal mine dust exposure simply because he may also have a lung impairment caused by smoking. “This is especially significant given that the post bronchodilator studies offered by Dr. Hippensteel and Dr. Castle, as well as the pre and post studies offered by Dr. Rasmussen, were all indicative of total disability in this case. In other

words, if we accept the values offered by the employer's physicians that suggest reversibility, the condition is still disabling once full reversibility has been established. Reversibility does not erase the fact that there remains a disabling obstructive impairment despite the effect if the bronchodilators. It is this portion of the impairment that was caused by coal mine dust exposure as indicated by Dr. Rasmussen."

I agree. On the first examination Dr. Rasmussen noted that the pulmonary function studies revealed severe, slightly reversible obstructive ventilatory impairment. The diffusing capacity was moderately reduced. There was minimal resting hypoxia. He was mildly hypoxic during exercise testing. Overall, the studies indicated marked loss of lung function due to severe obstructive impairment. On the second, Dr. Rasmussen noted, Pulmonary function studies revealed a severe, irreversible obstructive ventilatory impairment with a moderately reduced diffusing capacity. There was minimal resting hypoxia. Overall, the studies indicated the presence of marked loss of resting lung function as reflected by the pulmonary function studies sufficient to cause disability. Dr. Rasmussen determined that the condition was caused by a combination of smoking and coal mine dust exposure given that the effects of each cannot be distinguished by physical, physiologic or radiographic means.

Employer reminds me that Dr. Rasmussen is not board certified in pulmonary medicine. I note that is true. However, Dr. Rasmussen is "an acknowledged expert in the field of pulmonary impairments of coal miners." 1972 U.S. Code Cong. Adm. News 2305, 2314. As the Sixth Circuit Court of Appeals more recently stated, "Dr. Rasmussen's curriculum vitae establishes his extensive experience in pulmonary medicine and in the specific area of coal workers' pneumoconiosis." ***Martin v. Ligon Preparation Co.***, 400 Fed. Sup. 302 (6th Cir. 2005).[11] I am also advised that Dr. Rasmussen did not have access to all of the relevant data. His conclusions therefore cannot be credited over the contrary assessments offered by Drs. Castle and Hippensteel. However, I have already discussed why I should attribute less weight to their opinions.

The Employer objects that Dr. Rasmussen asserts there is no way to separate between cause of impairment or aggravation by smoking and coal dust. Although both Dr. Castle and Dr. Hippensteel reject this opinion, they did not articulate a basis to reject it. On the other hand, I find that their rationales are unpersuasive. They do not critique any particular study or any specific data behind a study. In fact, they do not address the effect of a combination of coal mine dust and smoking. Dr. Castle identified risks from a congenial condition, from coal mine employment, from smoking and from a cardiac impairment, but carrying his initial logic to the facts does not rule out <u>any</u> of these as contributing to the disabling breathing deficit. The Claimant only has to establish that coal dust or coal mine employment was a factor. ***Hobbs v. Clinchfield Coal Co.***, 45 F.3d 819 (4th Cir. 1995)

For all of the above reasons, I find that the Claimant has established legal pneumoconiosis by Dr. Rasmussen's reasoned medical opinion. 20 C.F.R. §718.202(a)(4).

CAUSATION

A miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 CFR 718.203(b). I have discounted the opinions of Drs Castle

[11] By unpublished decision in ***Bethenergy Mines, Inc. v. Director, OWCP [Rowan]***, Case No. 01-2148 (4th Cir. Sept. 4, 2002) (unpub.), the Fourth Circuit held that it was proper to accord greater weight to Dr. Rasmussen's opinion that the miner's centrilobular emphysema was caused by, or aggravated by, coal dust exposure.

and Hippensteel, who do not accept a diagnosis of pneumoconiosis, which is contrary to the full weight of the evidence. ***Scott v. Mason Coal Co***., 289 F.3d 263 (4th Cir. 2002); ***Tapley v. Bethenergy Mines, Inc***., BRB No. 04-0790 BLA (May 26, 2005) (unpub.). The record establishes 24 years of coal mine employment. I credit the opinion of Dr. Rasmussen on this point. Therefore, I find that the miner's pneumoconiosis arose at least in part out of coal mine employment.

TOTAL DISABILITY

To receive black lung disability benefits under the Act, a claimant must establish total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

The record does not contain sufficient evidence that Claimant has complicated pneumoconiosis and there is no evidence of cor pulmonale with right sided congestive heart failure. As a result, the Claimant must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

I find that the Claimant's respiratory medical profile precludes performance of his past relevant work. I accept Dr. Rasmussen's opinion on this issue. Again, I discount the opinions of Dr. Castle and Hippensteel, who do not accept either clinical or legal pneumoconiosis. ***Scott v. Mason Coal Co***., 289 F.3d 263 (4th Cir. 2002).

Therefore, I find that the Claimant has established the criteria under 20 CFR § 725.309, total disability.

ENTITLEMENT

I find that Claimant has established entitlement to benefits. Pursuant to 20 CFR §725.503, benefits are payable as of the month of onset of total disability and if the evidence does not establish the month of onset, benefits are payable beginning with the month during which the claim was filed.

The Claimant was evaluated by Dr. Rasmussen in March, 2005. DX 14. I accept the determination that the Claimant was totally disabled due to pneumoconiosis at that time, and it is reasonable to expect that he had the same symptoms when he applied on December 22, 2004.

Therefore, I find that benefits are payable as of the month during which Claimant filed the claim, December, 2004.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. ***Bankes v. Director***, 8 BLR 2-l (l985). The application must conform to 20 C.F.R. 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet

showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

The claim for benefits filed by **D.L.S.** is hereby **GRANTED**. Augmentation benefits for two dependents are also granted.

A

DANIEL F. SOLOMON
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).